

A Behavioral Health Education and Research System for Nebraska

**Nebraska Department of Health and Human Services
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Nebraska Behavioral Health Reform

Academic Support Work Group

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Introduction

Nebraska is reforming the state behavioral health system, moving from institutional care to community care and increasing the recovery focus of services. These reform efforts are consistent with the national vision outlined by the President's New Freedom Commission final report, *Achieving the Promise, Transforming Mental Health Care in America*, (Hogan 2003) (Iglehart 2004), which recognized the importance of having health care providers rely on up-to-date knowledge in the delivery of services.

This need has been recognized by LB 1083, which reformed the mental health system, by state and regional leadership, by the Nebraska Academic Support Work Group, and by the Rural Health Advisory Committee. Any reform of behavioral health education in the state should be compatible with the national efforts to change behavioral health care. The President's Executive Order of April, 2002, establishing the New Freedom Commission, set forth the following principles:

1. Focus on the desired outcomes of mental health care, which are to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation.
2. Focus on community-level models of care that efficiently coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services.
3. Focus on those policies that maximize the utility of existing resources by increasing cost effectiveness and reducing unnecessary and burdensome regulatory barriers.
4. Consider how mental health research findings can be used most effectively to influence the delivery of services.
5. Follow the principles of Federalism, and ensure that its recommendations promote innovation, flexibility, and accountability at all levels of government and respect the constitutional role of States.

Many components of the system of care will impact the success of this reform. One element of the system that is fundamental to the success of the reform is the development of a workforce that delivers the most efficient and effective services, and works with consumers to work for themselves and each other to develop the competencies that teach and promote self-directed recovery and getting a life.

It is essential that Nebraska have a well-organized behavioral health education and research system to develop the state-wide workforce necessary to support behavioral

health reform. As stated in the President's New Freedom Commission Report overview to Goal 5, "Excellent Mental Health Care is Delivered and Research is Accelerated":

In a transformed mental health system, consistent use of evidence-based, state-of-the-art medications and psychotherapies will be standard practice throughout the mental health system. Science will inform the provision of services, and the experience of service providers will guide future research. Every time any American - whether a child or an adult, a member of a majority or a minority, from an urban or rural area - comes into contact with the mental health system, he or she will receive excellent care that is consistent with our scientific understanding of what works. That care will be delivered according to the consumer's individualized plan.

Just as there is a crisis in the behavioral health service system, there is an identified crisis in the education system that produces behavioral health professionals (Hoge 2002). The education system lags behind in translating current research into training and thus into service delivery. In addition, consumers, now active in policy discussions and direct care, have been neglected in the training and education process. The Annapolis Coalition on the Behavioral Health Workforce <http://www.annapoliscoalition.org/>, a national coalition of American College of Mental Health Administration (ACMHA) and the Academic Behavioral Health Consortium (ABHC), addresses this in the Policy to Service report (Daniels 2005):

A clear crisis exists in the current behavioral health workforce. The Quality Chasm report has identified this as a central factor in the process of systems reform. The President's Commission also champions the improvement and expansion of the workforce and their ability to provide evidence based care. Together, these reports suggest that there is a serious problem in the development and deployment of the professional workforce. While behavioral health care has changed dramatically over the past fifteen years, the educational systems that prepare the workforce have failed to keep pace. In addition, while the voice of the behavioral health consumer has grown in policy discussion, and their role has also proliferated in direct care, their participation in the training and education process has been limited at best. Payment and training incentives have lagged behind this expanding role.
http://www.acmha.org/publications/From_Policy_To_Service.pdf

The Nebraska behavioral health reform would be enhanced by the development of a behavioral health education system that would increase the availability of behavior health providers to all areas of the state, assure that local service providers have knowledge and expertise in the best behavioral health practices, and ensure that the consumer's perspective be a component of education for providers.

This need has been recognized in the reform legislation, and has been addressed by Governor Mike Johanns and Senator Jim Jensen's request to the two academic health centers in the state for an outline of how the academic health centers could support system reform. A white paper outlining a Center of Excellence in Behavioral Health Care was presented to the Senator and Governor in December, 2003. [See Appendix A]

In order for system reform in behavioral healthcare to succeed, there will need to be significant changes in the behavioral health workforce, and the education and research activities that support them. Behavioral health providers will be needed in all areas of the state to provide treatment and rehabilitation services in a continuum of care ranging from

emergency services to long term care, rehabilitation and supports. Educational activities must support the extension of services to underserved geographic areas as well as the development of emerging consumer organized and operated services. The behavioral health reform legislation has charged each of the six Regions of the state with the responsibility to identify local behavioral health needs and develop a plan to meet those needs. These service plans do not address the need to train people to deliver care. Development of a behavioral health workforce requires a statewide plan to coordinate academic and education efforts across the state.

Coordinated research activities are another essential element of the behavioral health system that must be addressed. The 1990's were identified as the "Decade of the Brain" and tremendous new knowledge of brain function has been developed in the past 15 years. Translation of this knowledge into the daily practice of practitioners is so slow that it has been estimated to take 17 years to translate known science into clinical practice (Balas 2001) (Committee on Rapid Advance Demonstration Projects 2002). In its landmark monograph, Crossing the Quality Chasm: A New Health System for the 21st Century (Committee on Quality of Health Care in America 2001), the Institute of Medicine identified significant issues that impact the quality of care and that requires clinical care to be based on the best available scientific knowledge. In 2001, the ACMHA developed a companion to the Quality Chasm that focuses on the behavioral health system (Daniels 2005). The Institute of Medicine is continuing to develop quality materials focused on the behavioral health system, and a new Institute of Medicine monograph titled "Crossing the Quality Chasm - Adaptation to Mental Health and Addictive Disorders is under development. <http://www.iom.edu/project.asp?id=19405>

The importance of research to the national scene is indicated by the extensive funding for research in both business and government. Faculty members in academic institutions recognize that participation in research keeps them connected with the most up to date information about illness and treatment. At the local level, research activities, and academics in general, are at risk to be viewed as "ivory tower", with little to contribute to the immediate needs of the system. Appropriate research will enhance the system by decreasing the time it takes to translate science into services and by assisting payers, providers and consumers to identify the most beneficial treatments. (Ganju 2003)

Although this paper has its focus the Behavioral Health Education and Research System, it is necessary to address the interdependence between education, research and services. Behavioral health education and research activities are dependent on the service system for training opportunities and research material, and conversely, the service system cannot deliver quality services without well-trained and educated professionals. Research cannot occur without participants. Likewise, research is most meaningful when it addresses questions that have arisen in service delivery. Of particular interest is education and research that will meet the training needs for professionals throughout the state who provide care for persons with serious and persistent mental illness and co-occurring substance abuse problems that require a team of people to meet their needs. The move from institutional care to community care is especially relevant to people who have formerly received services from the Regional Centers. These people's needs are

usefully categorized under the rubric of individuals diagnosed with *serious mental illness* (SMI). In order to optimally enhance mental health reform in Nebraska, a behavioral health education center will need to address those aspects of education, training, practice and policy most pertinent to the lives of people diagnosed with SMI.

There is a concern that education and research activities will decrease the dollars available for services. There are limited dollars in the state for behavioral health activities, and the commitment has been made by the legislature that no service dollars will be used to fund the education and research effort. Likewise, the legislature has recognized the essential nature of academic support to the success of the reform effort, and the legislation requires the promotion of research and education to improve quality of services and the recruitment and retention of behavioral health professions.

Nebraska's Current Behavioral Health Education and Research System

There are numerous academic institutions in Nebraska that provide education and training for behavioral health professionals. These education programs are housed within universities and colleges across the state and are driven largely by accreditation requirements for each profession, faculty interest and expertise, student enrollment, and the availability of practicum location.

At present, behavioral health education delivery is fragmented and occurs in silos:

- Departments within academic institutions across the state recruit and train professionals such as psychiatrists, psychologists, social workers, nurses, and other professionals who work in behavioral health care
- Physician and psychology intern locations are influenced by funding available for graduate student salaries and benefits
- The State and Regions fund various workshops
- Education of substance abuse providers occurs in separate workshops and seminars
- Service provider organizations offer in-service education
- Professional societies provide various workshops
- The concept of consumers as providers is not well known in Nebraska, however peer specialists have been employed in clubhouses for six years and are required members of ACT teams.

Behavioral health education and training also occurs outside academic institutions with workshops funded by the state, regions, professional societies, drug companies, and in-service education in various provider organizations. This type of education and training is particularly important for the behavioral health system for several reasons:

- Non-professional providers, who get most of their training outside academic institutions, are important in the delivery of care (e.g., rehab workers, peer providers)
- Service delivery for persons with the most severe illness requires a team of people, and current academic training does not teach teamwork

- Continuing education improves the translation of research into service delivery
- Service delivery needs identified by the state and region can be addressed in workshops
- Cross training of professionals can be addressed (e.g., primary care doctors delivering behavioral health services, LADC/ LMHP cross training, etc.)
- Regulations may influence much of this training (LADC, continuing education requirements)

There is currently no system of behavioral health education that crosses professions and coordinates education efforts between academic institutions and community trainings. Also, there is clear evidence that the continuing education of professionals fails to translate new research findings into practice (Hoge; Tondora, and Stuart 2003; Huey 2002; Corrigan and Boyle 2003; Ganju 2003).

Education System

Practicing professionals recognize the need to collaborate with each other across disciplines in order to work as a team; however, the initial education of professionals is monolithic. What the professional gains as extensive expertise in their individual field frequently comes at the expense of learning teamwork and recovery and rehabilitation oriented skills.

The Medical College of Georgia has entered into a partnership with the Georgia Department of Human Resources that includes developing curricula for medical students and psychiatry and psychology residents that expand the recovery emphasis. A peer support specialist has been hired to work in the Department of Psychiatry and Human Behavior. www.mcg.edu/news/2005NewsRel/MHInitiative.html

Persons with serious behavioral health problems may experience long-term disability, persisting symptoms, or a relapsing course of illness, and treatment for these serious problems requires the professional to collaborate with many other providers (Kopelowicz and Liberman 1995; Hogan 2003). By the same token, it is possible for such individuals to lead self-directed and independent lives. Taking an example from general medicine, the role of the physician in the emergency room, when confronted by a patient who appears to be suffering from an acute heart attack, is very different than the role and communication skills necessary when the acute crisis is over and the focus is on regaining function and making life style changes in the rehabilitation phase of treatment. Likewise, persons with serious behavioral health problems benefit from various teams of providers and various treatment and rehabilitation techniques depending on the phase of active illness that is the current focus of treatment. (Lenroot; Bustillo; Lauriello, and Keith 2003)

The current education system does not foster interdisciplinary education in the way that practice must be accomplished. Training is driven by accreditation requirements, board

examinations, and state licensing requirements. Well established professions like medicine and nursing are slow to change. Other behavioral health professions such as alcohol and drug counselors may be better able to adjust curricula to the changing treatment requirements, however they lack a nationally recognized comprehensive curriculum and coordinated faculty. There have been efforts to train and certify peer specialists and rehabilitation workers, however these disciplines do not have nationally established training and accreditation requirements, increasing their flexibility in education but making it harder for their expertise to be recognized by licensed professionals. (Harwood; Kowalski, and Ameen 2004; Liberman and Kopelowicz 2002; Solomon and Draine 1994)

Although increased interdisciplinary education is an identified need in the educational system, it is not easy to bring about. Students expect their academic institution to prepare them for the rigors of professional practice and to cover the core educational requirements necessary in order to pass their board examinations. Also, accredited academic institutions must have an infrastructure adequate to support the education of professionals. While this infrastructure has benefits, it decreases flexibility and the ability to collaborate across departments, institutions and professions.

Research System

Mental health care is complex, expensive and important and deserves the research that is an essential component of a well-functioning system of care. There are numerous examples of academic/ service system partnerships that focus on behavioral health system research. The Agency for Healthcare Research and Quality (AHRQ) <http://www.ahrq.gov/> recognizes that research is only a beginning and not an end in itself. Connection with research can ensure that providers use best practices to deliver high-quality health care and to work with their patients as partners. Research evidence can also help patients to become better informed partners in their own care. Finally, research can help policymakers at the state and regional levels understand what they can do to improve the quality of health care for their constituents and ensuring that they have the latest information to help them make the best use of limited resources.

In Nebraska, State and Regional officials responsible for the behavioral health service system lack the resources to design and carry out the research that should guide the policy and treatment decisions. By partnering with academic institutions, which have research as a priority, these research needs can be addressed. (Bevilacqua; Morris, and Pumariega 1996) Linking research, policy making and treatment have the additional benefit of allowing researches and policy makers to learn from the insights of consumers of services and direct care staff about what they see that has worked (Blumenthal 2005). Consumers will also be direct participants, active in the planning, design, item development, survey administration, analysis and dissemination (Campbell and Schraiber 1989).

Assessment of need (GAPS)

The Annapolis Coalition has identified four paradoxes that characterize the education of providers in mental health and addiction services:

<http://www.annapoliscoalition.org/about.php>

- Graduate programs have not kept pace with the dramatic changes wrought by managed care and subsequent health care reforms, leaving students unprepared for contemporary practice environments.
- Continuing education models persist in using passive, didactic models of instruction that have been proven ineffective in controlled research.
- Non-degreed and bachelor-degreed direct care providers, who may have the most contact with consumers, receive very little training.
- Consumers and families, who play an enormous care giving role, typically receive no educational support.

These paradoxes must be addressed by Nebraska's behavioral health reform efforts.

Numerous efforts have been outlined to address the behavioral health education needs in Nebraska. Starting with the Center of Excellence white paper, and continuing through meetings at the state and local level focused on research and education, various proposals for a statewide education program have been outlined. This planning identifies the need for clinicians of all disciplines involved in providing behavioral health services including specialists in mental health and substance abuse to peer and primary care providers, and the need to train providers who will work in all areas of the state. One area that requires greater recognition and substantial development is the meaningful and significant inclusion of consumers, in processes such as these and including the recognition and provision of necessary supports that will enable consumers truly to participate in this processes. Involvement should be supported in ways that promote dignity, respect, acceptance, integration, and choice. Support should include whatever financial, education, or social assistance required. (NASMHPD, 1989)

The current fragmented training effort fails to encourage interdisciplinary teamwork among providers, target the highest needs in training, move training to more rural areas, obtain appropriate input from the network of agencies that will employ the trainees, and obtain sufficient grant funds. In addition, the lived experience of consumers being employed as trainers and informing professionals about training needs and similar participatory activities is not utilized in current training efforts. In terms of current training curricula, it would be important to include recovery concepts such as self-determination, empowering relationships, meaningful roles in society and eliminating stigma-discrimination and prejudice- throughout the various levels of professional and provider training.

In summary, the current education and research system in Nebraska is lacking the following:

- Training for professionals in teamwork and collaborative care

- Matching the local need for professionals with the education efforts in institutions
- Retaining trained providers in the state
- Recruiting high school and college students into behavioral health care professions
- Recruiting persons with psychiatric diagnoses into behavioral health care professions
- Support for rehabilitation workers and peer providers
- Academic support for rural rotations
- Support to keep providers updated on new treatments and best practices
- Developing research infrastructure
- Research to answer the questions important to the state and to consumers in order to inform the state about services, supports, evaluations and suggested changes.

Proposal

A Nebraska Behavioral Health Education System, composed of a Behavioral Health Education and Research Center, and six Behavioral Health Education Sites across the state addresses the needs.

Behavioral Health Education Center

A Behavioral Health Education Center would coordinate education across academic institutions and professions, support training for substance abuse, rehabilitation and peer providers, support clinical training in all areas of the state, and enhance research that improves the system of care.

The Center would have academic leadership with an Executive Committee, including representation from each participating academic institution, and would include consumers of services in sufficient numbers to make an impact and representation from the state. Faculty from UNO, UNK, UNL, Creighton, and UNMC and the consumers must work together to develop interdisciplinary education for trainees in undergraduate through post-graduate practitioners. Each of the higher education institutions and the consumer members on the coordinating committee will be allotted a budget from the state to allow faculty participation in the Behavioral Health Education Center in order to:

- develop the necessary collaborations with individuals and institutions across the state who would be providing clinical training and supervision
- modify curriculum to allow for external rotation sites
- provide supervision for local clinical training
- train students

As the center obtains further grant money, participation would be open to other academic campuses within the state. The Center would provide coordination and support for behavioral health sites throughout the state.

This faculty must also:

- collaborate with local providers and consumer and family communities to provide clinical supervision
- develop a continuing education curriculum which disseminates best practices throughout the state
- partner with consumers of services in curriculum development, education delivery, and the development of peer providers roles

The education to support behavioral health reform should include:

- education and re-training to support the paradigm shift to self-directed recovery, peer supports, community services, and independent community living.
- knowledge of and use of current best practices
- an effort to recruit and retain providers, including consumers, in all areas of the state
- expertise in the use of technology, including tele-health, to support education and outreach services
- research that supports the needs of the state that are relevant to consumers and involve consumers beyond the role of subject
- multidisciplinary training across professions and academic institutions, that reflects the teamwork needed in service provision

In order for the clinical training to occur in an interdisciplinary manner, the education center must be co-located with comprehensive services. The service location must be designed to support and facilitate education. This co-location has the advantage of directly connecting service to education, facilitating tele-health and outreach of services to other areas of the state functioning as a clearing house for education and training efforts across the state, facilitating financial support from grants, and providing an infrastructure to organize statewide behavioral health education and research. Faculty members from UNO, UNK, UNL, Creighton University, and UNMC would provide multidisciplinary supervision and teaching on-site and facilitate clinical supervision to trainees in all areas of the state. Educational facilities should include an auditorium, conference rooms, observation rooms for clinical training, a behavioral health library, offices for faculty and trainees, and tele-health and distance learning equipment and support staff. However, the primary educational facility shall be the community. The budget for this statewide education effort must be considered separately from the budget for services.

Behavioral Health Education Sites

Every area in the state needs well trained providers of behavioral health care. Sites in all areas of state would be provided their own budget and support from Area Health

Education Centers (AHEC). These plans for behavioral health education sites follow the successful Rural Health Education Network [\[Appendix B\]](#) model already available in Nebraska. Each training site would have local control of the professions that are the focus of training as well as recruitment and retention and would be expected to work with the Behavioral Health Regions and their Advisory Committees. A local coordinator would identify and recruit preceptors and assist with the arrangements for housing, meals, transportation and other services to facilitate student participation in rural rotations from the academic center partners. Plans include development of two rural sites each year during a three year period for a total of six sites throughout the state being operational at the end of three years. Tentative sites include Scottsbluff, North Platte, Grand Island, Norfolk, Lincoln, and Omaha.

Research

Research is an essential component of Nebraska's academic departments, and academic research activities can be developed which can:

- improve the system of care in Nebraska via services evaluation and outcomes research
- train, develop and involve consumers in services evaluation and outcomes research and all aspects of service planning and delivery
- teach clinicians “best practices” for high-quality and cost-effective care
- leverage federal, private and foundation sources for enhanced funding
- involve Nebraskans in leading edge research that translates advances in neuroscience, telemedicine and service optimization into genuine patient recovery
- collaborate with the private sector to study workplace behavioral health issues, reasonable accommodations and intervention strategies

Academic support for system and outcome research should focus on the questions of most interest to the state:

What services work best?

What is the most efficient and effective delivery of service for each problem?

Are our educational efforts being translated into improved service delivery?

Also, on the part of recipients of services, is the research relevant, asking such questions as “what could have prevented people from being committed”. Also, “what effect does involuntary treatment have on the use of voluntary services?” (Campbell and Schraiber 1989)

The Center will focus initial research activities on the special issues of highest interest to the state, such as epidemiology issues pertaining to people in Nebraska who have been diagnosed with severe and persistent mental illness, and new treatment evaluation and the identified manifestation and application for the paradigm shift to person-centered hope-oriented lives in the community. Examples of research activities that could eventually lie within the Center's scope include:

- Epidemiology (incidence and distribution of mental illness of various types and severity)
- Outcomes research (effectiveness of treatments and services approaches)
- Cost-effectiveness research (analysis of the costs compared to the benefits of treatments and other services)
- Public safety data
- Risk assessment and management research (analysis of the impact of clinical practice and related activities on public safety)
- New treatment development (developing and testing new treatments)
- Translational research (applying basic science to clinical problems)
- Workforce research (Tracking behavioral health professionals across disciplines in order to analyze demographic and workforce trends)
- Dissemination and implementation research

Later studies will focus on best practices and evidence-based practice to improve the quality of care available in local communities. State funded outcome-research activities will be developed in collaboration with HHSS behavioral health leadership. State funded personnel will provide the infrastructure to develop the research component.

With some state support, Nebraska can develop a multi-institutional, inter-disciplinary academic group oriented towards developing a comprehensive, statewide research infrastructure for policy-relevant mental health services research. (Hoge 2002) This group can continue the work of the Academic Support Workgroup by developing best practice guidelines and Tele-Health Network, providing infrastructure support for grant applications, and assisting the state and regions in developing the data to answer their most pressing policy questions.

Conclusion

Nebraska is beginning the behavioral health transformation process that will make it possible to meet the goals outlined in the President's New Freedom Commission report:

1. Americans Understand that Mental Health is Essential to Overall Health
2. Mental Health Care is Consumer and Family Driven
3. Disparities in Mental Health Services are Eliminated
4. Early Mental Health Screening, Assessment, and Referral to Services are Common Practice
5. Excellent Mental Health Care is Delivered and Research is Accelerated (that is where the "scientific is in "Understanding the Goal" section that comes after it.
6. Technology is used to access mental health care and information.

In order to meet these goals it is necessary to move from a separated and fragmented system of behavioral health education and service to one in which service, education, research, and consumer participation will become fully integrated and thus benefit from the particular perspective that each entity has as its focus.

At present, those involved in service delivery must meet the ever present and pressing need for providing care. Educators are concerned with preparing students to join the behavioral health workforce in a variety of careers and providing continuing education for those who are already part of the workforce. Researchers, lacking support to direct their efforts to the state's most pressing issues, focus on areas where grant support is more readily available. And the unique and personal experience of consumers is only beginning to be heard, acknowledged, and valued by the other behavior health entities.

Although the work of each discipline is equally important and dependent on the others, The Nebraska Behavioral Health Education Center and Sites will remove the barriers that exist between disciplines and provide collaborative bridges among service providers, educators, researchers and consumers so that the New Freedom Commission statement, "...excellent care that is consistent with our scientific understanding of what works" will be a reality in Nebraska. In addition, the Center and Sites will provide new avenues for dealing with the educational and service barriers that exist because of the distance between urban and rural populations, among diverse populations, and between providers and consumers of services. Finally, those individuals in state government who are charged with policy making and funding decisions will have support for the state's academic institutions in their effort to transform the behavioral health system.

Therefore, it is strongly recommended that the state develop a separately funded Nebraska Behavioral Health Education and Research System to meet the workforce and research needs of the state. This initial investment will improve behavioral health care in the state and assist in the development of external grant funding to support behavioral health education and research.

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Appendix A

The Nebraska Academic Health Centers Plan for Excellence in Behavioral Health

Submitted by
the University of Nebraska Medical Center,
Creighton University and the State of Nebraska

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UNIVERSITY OF
Nebraska
Medical Center

Creighton
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I. INTRODUCTION

Nebraska has significant and important unmet needs in behavioral health care. This problem has been accentuated by state budgetary shortfalls, hospital closures, and insufficient numbers statewide of providers. At the same time, Nebraska has two excellent academic medical centers whose capabilities, working with the state, might be utilized to improve the situation.

The state's two academic health science centers were charged by the Governor to develop a plan for the academic health center participation, using their educational, clinical, and research capabilities for behavior health care excellence in Nebraska statewide. The goal would be a model that improves access to outstanding clinical care and increases the number of behavioral health care professionals being trained and does so in a way that increases the number of providers throughout the state. The state's two academic medical centers have several areas of excellence in behavioral health research. The proposed plan should increase both the quantity and quality of research in Nebraska so that Nebraskans can be the primary beneficiaries. Finally, this effort should, whenever possible, work in concert with private industry and private health care providers to address Nebraska's particular needs and guarantee the maximal output for resources invested.

II. BEHAVIORAL HEALTH STATUS IN NEBRASKA

A. Current System

Organization

Mental health and substance abuse services are funded by state and federal funds through two separate administrative organizations. The public system or Nebraska Behavioral Health System (NBHS) is funded with state general funds, federal block grant funds (mental health and substance abuse) and cash funds (primarily tobacco settlement funds.) NBHS is comprised of the Office of Mental Health, Substance Abuse and Addiction, and Addiction Services, three psychiatric hospital (Regional Centers), and six behavioral health regions. The Medicaid system is funded with state general funds and federal funds. State expenditures are matched with approximately 60 percent federal match.

The NBHS contracts with the six mental health and substance abuse regions within the state to deliver services. The NBHS provides treatment and rehabilitation services to primarily the adult population. The regions are responsible for providing emergency services and a continuum of behavioral health services in the community. Regions contract with providers for specific service types and capacities. The goal is to move consumers from high intensity care to living as independently in the community as possible. The availability and capacity of services is limited by legislative appropriation. Regardless of the demand for services total funding is capped.

The Medicaid system operates under a fee-for-service payment system with a statewide-managed care mode. Approximately two-thirds of the Medicaid expenditures are for services for children and one-third pays for services to adults. Medicaid services must meet federal medical necessity requirements. Services must be provided to any person who is Medicaid eligible and in need of treatment. Funding shortages, when they exist, are made up through deficit appropriations made by the Legislature.

Nebraska Health and Human Services System (HHSS) also operates three regional centers or psychiatric hospitals, which provide inpatient acute and secure mental health services as well as forensic, adolescent, and sex offender services.

Number and Type of Patients

Prevalence estimates for 2000. According to the U.S. Department of Health and Human Services, prevalence estimates indicate that:

1. There are 23,537 children and adolescents aged 9 to 17 in the state who are “Seriously Emotionally Disturbed” (SED).
2. There are 67,701 adults with “Serious Mental Illness” (SMI). Serious mental illness is a term defined by Federal regulations that generally applies to mental disorders that result in functional impairment.
3. About half of those individuals with SMI are identified as being even more seriously affected, that is, they have “severe and persistent” mental illness (SPMI). This category includes schizophrenia, bipolar disorder, other severe forms of depression, panic disorder, and obsessive-compulsive disorder.
4. Among the most severely disabled with SPMI are those who receive disability benefits for mental health related reasons from the Social Security Administration. This number is estimated at 6,269.
5. There are 35,345 youth aged 9 to 17 who abuse alcohol and drugs.
6. It is estimated that there are 209,661 adults who abuse alcohol and drugs.

Regional Center statistics. Tables listed in Appendix B outline the number of admissions to acute and secure levels of care at Nebraska’s three regional centers, the number of consumers committed to and admitted to in-patient care at regional centers by region, and the lengths of stay for patients.

Expenditures. A table in Appendix C outlines expenditures for fiscal year 2003 for adults in the behavioral health systems funded by HHSS.

Workforce supply. Twenty-one of Nebraska’s 93 counties have no licensed mental health professionals (psychiatrists, psychologists, social workers, counselors, or marriage and family therapists). Another 24 counties have only one mental health professional. The locations of mental health professionals, according to the University of Nebraska Medical Center’s Health Professions Tracking Center, are shown in the following table:

	Psychiatrists		Child/Adol. Psychiatrists		Nurse Practitioners		Physician Assistants		TOTALS	
	#	%	#	%	#	%	#	%	#	%
Region 1	5	4%	1	5%	1	5%	0	0%	7	4%
Region 2	4	3%	1	5%	0	0%	0	0%	5	3%
Region 3	16	13%	3	14%	3	15%	0	0%	22	13%
Region 4	7	6%	0	0%	0	0%	2	40%	9	5%
Region 5	23	18%	3	14%	4	20%	1	20%	31	18%
Region 6	72	57%	13	62%	12	60%	2	40%	99	57%
TOTAL	127		21		20		5		173	

According to the Nebraska Office of Rural Health and Primary Care, regions 1 through 5 are designated mental health professional shortage areas. In 1998, there were 6.7 psychiatrists

per 100,000 population in Nebraska. Nebraska fell below the national average of 11.1 and ranked 37th among states in psychiatrists per capita.

Thirty-seven of Nebraska's 93 counties are considered to have a shortage of nurses, according to the list of "Nursing Shortage Counties" compiled by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions.

Certified professionals. The number and location of psychologists, substance abuse counselors (CADAC), and Licensed Mental Health Professionals (LMHP) certified by HHSS are shown below:

	CADAC	Prov. CADAC	LMHP	Prov. LMHP	Psycholo- gists	TOTAL
Region 1	21	8	64	22	8	123
Region 2	11	7	65	17	5	105
Region 3	60	21	213	63	28	385
Region 4	20	22	114	61	21	249
Region 5	89	59	493	183	129	963
Region 6	110	63	815	329	137	1454
Multi-Region	24	5	152	9	20	210
TOTAL	346	185	1916	684	348	3479

Abbreviations:

CADAC – Certified Alcohol and Drug Counselor

CPADAC – Provisional Certified Alcohol and Drug Counselor

LMHP – Licensed Mental Health Practitioner

PLMHP – Provisional Licensed Mental Health Practitioner

In 1998, Nebraska had 26.5 psychologists per 100,000 population, lower than the national average of 31.2. Nebraska had 205.3 social workers per 100,000 population in 1998, lower than the national average of 216.0. (Source: Health Resources and Services Administration of the U.S. Department of Health and Human Services).

A. Nebraska's Needs/Gaps

What are the needs? In October 2001, The Office of Mental Health, Substance Abuse and Addiction Services contracted with the Western Interstate Commission for Higher Education (WICHE) Mental Health Program to perform a study of the need for mental health services in Nebraska. The study, titled *Nebraska MHSIP/Prevalence, Utilization, and Penetration*, utilized information from both NBHS and Medicaid information systems to make the following estimates of people being served and the unmet need:

	Person SMI or SED (Federal Estimate)	Individuals Served	% Served	Unmet Need
Youth	23,537	18,607	79%	4,930
Adults (18+)	67,701	23,128	34%	44,573
TOTAL	91,238	41,735	46%	49,503

What are the gaps? HHSS has identified a number of gaps in services that result in extensive waiting periods from the time a person's needs for services are identified to the time they can be served. Extensive wait lists exist for consumers seeking mental health and substance abuse services in the community. In addition, persons who have been committed to regional centers must wait several days before they can be admitted. At the same time patients ready to leave regional center services cannot find appropriate services in the community. Several gaps in services can be identified as contributing to this problem.

- There is insufficient capacity of behavioral health services in the community. Based on the table above, the level of demand for services exceeds the capacity of services by an estimated 54 percent. The funding level established for providing behavioral health services in the community is not sufficient to provide additional services. This results in consumers not being served and patients at regional centers who are ready for discharge being held until an opening occurs or being discharged to a service or facility that cannot support their needs.
- There is not an adequate supply of affordable, safe, and appropriate housing for people with extremely low income with Serious Mental Illness (SMI). It is estimated that more than 3,000 housing units across the state are needed to support individuals who need behavioral health services and have an extremely low income.
- There is no single state behavioral health system in Nebraska. For example, NBHS and Medicaid are funded through separate funding streams and administered in separate agencies that are part of the Nebraska Health and Human Services System.
- There is insufficient capacity of appropriate services for youth who are transitioning from adolescent services to adult services.
- The state's information system is inadequate to track and manage the delivery of behavioral health services. HHSS currently depends on four separate information systems to collect and maintain consumer information.
- The cost of medication for persons with serious mental illness, youths with severe emotional disturbance and persons with chemical dependency makes it difficult for these consumers to access necessary medication.
- Persons in rural areas and elderly persons are being underserved in relation to other population groups within the system.
- There is a lack of culturally competent service providers within the behavioral health system.

III. ROLE OF ACADEMIC HEALTH CENTERS IN AN IMPROVED BEHAVIORAL HEALTH SYSTEM

A. Education

The following section details the current educational programs in behavioral health, the needs of the state in behavioral health education, the gaps in how current programs meet those needs, and how we might redesign educational training to better meet the behavioral health needs of the state.

Assets and Strengths

Nebraska currently has a formidable array of educational institutions providing training in behavioral health service (mental health and substance abuse services). Those programs include the following clinical training programs whose training specializes in behavioral health:

- Psychiatry Residency Training, provided by Creighton University and UNMC
- Psychology Graduate Training, provided by the University of Nebraska-Lincoln (UNL) and the University of Nebraska at Omaha (UNO)
- Social Work Graduate Training, provided by UNO
- Nursing Graduate Training, provided by Creighton University and UNMC
- Master's Level Psychotherapy Training, provided by Creighton University, UNL and UNO
- Certified Alcohol and Drug Abuse Counselor Training, provided by multiple institutions
- Marriage and Family Therapy Training, provided by UNL

In addition, there are numerous graduate level training programs in primary care and other areas of medical practice, whose practitioners might devote considerable time to delivering behavioral health services. Those include programs such as family practice residencies, internal medicine residencies, pediatric residencies, emergency medicine residency, physicians assistant training programs and advanced practice nursing programs. These programs are multiple, and Creighton University and UNMC provide much of the institutional support.

Exposure to behavioral health delivery also occurs at the undergraduate level in departments such as social work and psychology at colleges and universities throughout the state. Many of the para-professionals (non-graduate level care providers) who deliver services in the public sector receive their training in such programs.

Another important aspect of training is that of professionals involved in the administration of the state's health system. Clinicians and non-clinicians provide this area of health care policy, which includes systems research, outcomes research, epidemiology and administration. Formal graduate level training and other programs in these areas are provided by the UNMC Department of Preventive and Societal Medicine, the UNO College of Public Affairs and Community Services (which includes the Schools of Social Work, Public Administration, Criminal Justice, Gerontology, and Urban Studies), Creighton University School of Business and the Creighton Center for Health Policy and Ethics.

Other groups involved in behavioral health training of potential relevance to the Nebraska Center of Excellence for Behavioral Health (the Nebraska Center) include the newly formed Nebraska Consortium on Psychotherapy Training -- an umbrella group of graduate programs providing psychotherapy training -- and the Center for Psychotherapy and Psychoanalysis -- which provides

post-graduate (continuing education) programs which may be of relevance to the behavioral health field. Both of these groups are interdisciplinary and inter-institutional.

It also is worth noting that numerous distance-learning programs currently exist throughout the state at different levels of training and for different purposes.

Assessment of Need

- **PRACTITIONER NEEDS** -- The state needs physicians, nurses and other practitioners at all levels of training dedicated and committed to working with the population served by the state. Any training program with state investment, such as the proposed Nebraska Center, should provide this as the most critical educational mission. This should include the education of practitioners at all levels of training, from doctoral to masters to undergraduate trained providers.
- **CLINICAL TRAINING PROGRAM NEEDS** -- The varied training programs detailed in the Assets and Strengths section need to incorporate training in state-supported behavioral health as a critical part of their training programs. This should include training in the conditions relevant to the population and should occur as part of all trainees' clinical experience. It also should be available as an area of special focus to train those with a commitment to public service.
- **EXPOSURE TO HEALTH CARE SYSTEMS, RESEARCH AND OUTREACH** -- In order to make clinicians more effective working within the system, training programs need to enrich the clinical training with research and outreach training in public health systems. This should include enhanced interaction between clinicians, policy experts and public mental health advocates.
- **RECRUITMENT** -- The state needs targeted recruitment for providers of all backgrounds into the public-sector mental health system.

Identified Gaps

Relative to the areas identified as needs immediately above, the following gaps exist in the state's educational system for behavioral health providers:

- **PRACTITIONER GAPS** -- Too few providers understand the special clinical issues relevant to the state's public health population in many of the training programs. This is especially true with regard to severe and persistent mental illness (patients whose diagnosis and condition are not very prevalent, but whose severity leads them to require a significant greater proportion of clinical resources). Interdisciplinary approaches are not used as much as they might be. Collaboration with primary care colleagues is not adequately utilized. An emphasis on rehabilitation is lacking. Many providers do not adequately utilize intermediate levels of care (where they even exist) and have no practice in long-distance clinical care or consultation.
- **CLINICAL TRAINING PROGRAM GAPS** -- Most programs do not provide sufficient mandatory training in state-sponsored behavioral health, nor do they offer specialized training for those interested in pursuing practice opportunities in public-sector behavioral health.
- **EXPOSURE TO HEALTH CARE SYSTEMS, RESEARCH AND OUTREACH GAPS** -- Outreach training (eg, telephone or televideo consultation) is rare among the state's training

programs. Many programs offer little contact with public policy research or advocacy in mental health. Exposure to health care systems issues is lacking in some programs.

B. Research

Research is an essential component of the Nebraska Center, which is nationally recognized and responsive to the needs of the citizens of Nebraska. The Nebraska Center can provide funded researchers with the facilities to conduct research, which can:

- **improve** the system of care in Nebraska via services evaluation and outcomes research
- **teach** clinicians “best practices” for high-quality and cost-effective care
- **leverage** federal, private and foundation sources for enhanced funding
- **involve** Nebraskans in cutting-edge research that translates advances in neuroscience, telemedicine and service optimization into genuine patient recovery
- **collaborate** with the private sector to study workplace behavioral health issues and intervention strategies

Assets and Strengths

The following section tabulates current research strengths at UNMC, Creighton and collaborators; assesses needs for program expansion; identifies gaps in current research programs; and makes specific recommendations for steps to promote research, which address needs specific to mental health care in Nebraska.

- **UNMC**
 - **General Research & Funding**
 - **New Grants:** FY 01-02: \$50,775,191; FY 02-03: 55,896,393; 1st Quarter FY 03-04: \$26,000,000
 - **Funding-** 68% Federal, 8% State, 15% Industry, 9% Other
 - **Active research grants:** 362 grants awarded to 208 investigators in the past fiscal year
 - **Current Mental Health Research at UNMC**
 - **Research in the Department of Psychiatry:** 23 active grants
 - psychopharmacology of Alzheimer’s, anxiety, depression, and ADHD (NIMH, Foundation and industry funding)
 - genetics of ADHD and depression (NIMH and Foundation funding)
 - treatment of adolescents with depression (NIMH funding)
 - immune function and stress (Foundation and Industry funding)
 - **Department of Psychiatry Research Infrastructure:** 13 full-time staff (1 assistant director, 6 study coordinators, 3 research assistants, 2 administrative assistants, 1 administrator), 4 exam rooms, 2 small laboratory, 8 offices, 2 medical records rooms
 - **Other Colleges/Departments Conducting Mental Health Research:** Munroe-Meyer Institute-Genetics and Molecular Biology (ADHD, Reading Disability) and Psychology (Mental health and primary care partnerships, Training and maintaining behavioral health professionals in rural Nebraska); Departments of Pediatrics, Pharmacology, Radiology, Otolaryngology, Internal Medicine (smoking cessation), College of Nursing (stigma, health promotion in severe mental illness)
- **Creighton University**
 - **General Research & Funding**
 - **New Grants -** FY 01-02: \$34,840,000; FY 02-03: \$36,200,000
 - **Funding -** 52% Federal, 13% State, 22% Industry, 13% Foundation, 1% Other
 - **Active research grants -** 929 grants awarded to 197 investigators in the past fiscal year
 - **Current Mental Health Research at Creighton**

- **Research in the Department of Psychiatry:** 21 active grants
 - psychopharmacology of bipolar, depression; schizophrenia; anxiety; PTSD; anorexia, obesity and metabolism; substance abuse; cultural disparities (NIMH, Foundation and industry funding)
 - neuroscience and genetics of psychopathology (VA and Foundation funding)
 - neuroimaging of mood and psychotic disorders (Foundation funding)
 - community and faith-based behavioral health (US-HHS funding)
 - policy and services research; forensic psychiatry and ethics, dual diagnosis mental illness and substance abuse (Foundation funding)
 - **Department of Psychiatry Research Infrastructure:** 7 full-time staff (3 study coordinators, 2 research assistants, 1 administrative assistant, 1 administrator), 1 exam rooms, 4 offices, 1 medical records rooms (neuroscience wet-laboratory facilities are under the direct auspices of the VAMC)
 - **Other Colleges/Departments Conducting Mental Health Research:** College of Nursing, College of Pharmacy, College of Dentistry, Occupational Therapy, Center for Health Policy & Ethics, Department of Pediatrics, Department of Family Practice, Center for Psychotherapy, Institute for Medicine & Law, Program in International Health Research
- **Examples of Current Collaboration between Nebraska's Academic Health Centers**
 - **UNMC & Creighton**
 - The Vice Chancellors for Research at UNMC and UNL recently held a conference with representation from the National Institutes of Health and 64 behavioral health researchers from UNMC, UNL, UNO and Creighton. The goal: to foster collaboration among Nebraska researchers in behavioral health, discuss potential new lines of research, and to develop collaborations, which could facilitate funding from external agencies.
 - UNMC, Creighton and the Veteran's Administration have provided a model for collaboration in clinical work and research at the Veteran's Administration Medical Center in Omaha and throughout Nebraska and Western Iowa.
 - UNMC and Creighton Psychiatry Vice Chairs for Research co-direct a research seminar at the Omaha VA for resident physicians
 - An informal network of behavioral health researchers from CU, UNMC and UNL who meet to discuss ongoing research and potential areas of collaboration. They already have achieved success with David Bylund, Ph.D., UNMC professor of pharmacology, and Frederick Petty, M.D., Ph.D., Creighton University professor of psychiatry, receiving NIH funding for studies of pediatric depression using an animal model.
 - Institutional Review Boards: NIH funded project to improve human subjects protections and promote collaboration between CU and UNMC research review boards.

Assessment of Need

- **Nebraska needs:**
 - Expanded access to clinical trials to providers and patients throughout the state.
 - Information adequate for evidence-based resource allocation for the treatment of chronic and persistently mentally ill across Nebraska.
 - Ongoing investigation and evaluation of best practice guidelines for use in treatment of those with behavioral health needs in rural and urban Nebraska.
 - Research into effective mental health delivery systems for rural and frontier areas
 - Research into effective strategies for telemedicine
 - Establish mechanisms by which Nebraska can meet and surpass national benchmarks for mental health treatment.
- **Research & Development Infrastructure needs:** Creighton and UNMC already have productive research enterprises, but the modest resources devoted to infrastructure limit the capacity and constrain further growth of the programs. By combining the strengths of each

of the medical centers and their collaborators, their complementary resources and expertise will fill some of the gaps of the individual programs. Further development will require additional clinical and basic science facilities in order to optimize current lines of research; recruit and retain junior, as well as senior investigators; expand into additional areas of interest to the citizens; and fully meet the needs/expectations of the state.

Identified Gaps

- Additional **researchers** with experience and external funding are necessary to further develop areas of strength and to extend the current lines of research to new areas of interest.
- Very limited **laboratory space** is available at this time.
- Researchers in the state with overlapping areas of interest/expertise need to be brought together to **facilitate collaboration** and build upon strengths.
- **Training** students, resident physicians, and practicing clinicians in quality improvement research
- Lack of adequate **office space** is currently constraining further development.

C. Services

This section will review how the academic medical centers can contribute to clinical services provided by the Nebraska Center. It will include a description of the various assets and strengths in the medical centers that can be applied to the state's public sector behavioral health needs. It also will review needs as they relate to services, and identify gaps in services.

Assets and Strengths

The academic health centers are uniquely positioned to help improve behavioral health care in Nebraska by providing state-of-the-art care that is enhanced by connection to education and research. UNMC and Creighton University Medical Center have numerous resources that can address some of the state's behavioral health needs. A brief list of resources includes:

- Numerous faculty and staff who currently work in behavioral health areas, including:
 - Academic psychiatrists (38)
 - Nurse practitioners specializing in psychiatry (4)
 - Physician assistants specializing in psychiatry (2)
 - Primary care doctors (69)
 - Nurse practitioners specializing in primary care (20)
 - Physician assistants specializing in primary care (5)
 - Dozens of faculty in nursing, pharmacy, psychology and counseling, social work and occupational therapy programs.

In addition, the academic medical centers have programs that provide state of the art behavioral health care. Examples include:

- The Assertive Community Treatment Team
- The Intensive Case Management program at the Veteran's Administration Hospital
- Dual Diagnosis Treatment Center at the Veteran's Administration Hospital
- An emergency medicine residency program
- The Child and Adolescent psychiatry residency program
- UNMC Family Health Care Center staffed by nurse practitioners
- The Center for Psychotherapy

The academic medical centers and affiliates also have faculty with broad experience and expertise in public mental health care and administration and other resources that support high quality, cost effective behavioral health care. Some of these resources include:

- Technology and staff to support tele-health services
- Experts in health care management
- Medical libraries with Web-based access to support clinician's information needs
- Education programs that bring national speakers to Nebraska
- Rural education support
- Extensive quality improvement programs

High quality services require support for outcome research activities that are similar to the research and development activities of good business operations. The state's academic health centers can support the behavioral health system by providing support from:

- The Health Professions Tracking Service
- The Nebraska Rural Health Education Network
- The Nebraska Center for Rural Health Research
- The Creighton Center for Health Policy and Ethics

Other academic institutions can contribute to the behavioral health care improvement mission of the state, notably, but not limited to, UNL and UNO. Indeed, virtually all interested institutions of higher learning would be welcome to participate in the creation of a statewide center of excellence.

In addition, there are excellent resources in Nebraska outside the academic centers, and every effort should be made to build on or partner with existing services. Professional organizations, non-profit community providers, Alegent, The Douglas County Hospital, community foundations such as The Kim Foundation, various groups such as the National Alliance for the Mentally Ill and the Nebraska Advocacy Service, Regional Center staff, and providers in local communities are some examples of excellent elements of the current system of behavioral health care are. While a variety of linkages exist between such entities and the academic health centers, it is anticipated that these connections would be greatly enhanced by the Nebraska Center.

Assessment of Need

This section will outline in a broad manner what is necessary for excellent behavioral health services.

- People with substance abuse and mental illness should have access to needed services within their communities or as close to home as possible.
- A behavioral health system must have a continuum of services from emergency and crisis services to inpatient care to mid-level care (such as residential care and intensive case management) to standard outpatient care to ensure that every patient receives the most appropriate, least restrictive, and most cost-effective treatment.
- There must be a process for surveying the local needs and resources throughout the state to identify those areas with provider and service surpluses and shortages and be prepared to intervene to assist communities in receiving appropriate staff and program support.
- There must be a system for monitoring the effectiveness and efficiency of the various treatment programs to identify and modify programs in light of their results.

- There should be special services available for persons with complex problems who have not responded to usual care. This service could be provided by direct referral to specialty services or by consultation to primary providers.

Identified Gaps

The behavioral health system in Nebraska has been extensively reviewed and there are many problems identified. These problems include fragmentation, poor access to a continuum of services, inadequate system monitoring and quality improvement, workforce issues, and insufficient consultation and outreach. The following issues need to be addressed:

- A comprehensive continuum of services that coordinates care across providers.
- Access to behavioral health services when they are needed without waiting lists.
- Middle intensity behavioral health services such as residential rehabilitation, intensive case management, peer support, and assertive community treatment.
- Services that support the recovery of persons with behavioral health problems. Acute care needs that threaten safety are often addressed just enough to allay the crisis, but not enough to sustain individuals in their community.
- Adequate services for children and adolescents, elderly persons with mental illness and services that are appropriate for persons with multicultural and multilingual needs.
- There is a severe shortage of child psychiatrists across the state.
- A provider tracking system for behavioral health similar to the system available for other health care providers.
- Emergency rooms lack access to professionals for behavioral health assessments and lack readily available placement options for people who need acute care but don't meet criteria for hospitalization.
- Primary care providers' doctors lack behavioral health professionals to take referrals.
- People whose problems have not responded to care do not have access to tertiary care providers.
- Nebraska lacks all levels of services for people who have both mental illness and substance abuse problems.
- Families in Nebraska lack access to family education programs.
- Nebraska has a limited behavioral health work force supply.
- There is limited use of video conferencing to provide behavioral health services.

IV. VISION FOR THE NEBRASKA CENTER OF EXCELLENCE

Nebraska's academic health science centers are poised to assist the state in creating the Nebraska Center for Excellence in Behavioral Health.

Statewide impact

The creation of the Nebraska Center of Excellence in Behavioral Health will promote, develop and refine mental health and substance abuse services in all communities and regions throughout the state. In addition to this essential service arm, the Nebraska Center will include educational and research arms to support the clinical mission. This care network will include clinicians of all disciplines involved in providing mental health services, from specialists in mental health to

primary care providers. The academic health science centers can support the state in numerous ways.

- Recruitment of students at all levels of training into behavioral health
- Coordination with clinical entities across the state to provide them with trainees serving internships and practica, with the goal that such exposure will bring clinicians to underserved -- especially rural -- areas
- Faculty appointments for clinicians throughout the state interested in participating in the educational activities with trainees
- Opportunities for interested clinicians throughout the state to participate in research programs in behavioral health
- Training programs for clinicians to be produced and transmitted throughout the state for continuing education
- Access to the expertise of the academic health science centers for consultation through a state-of-the-art media network for tele-health and tele-education
- Access to the Tertiary Care referral services coordinated by the academic health science centers
- Track behavioral health professionals across disciplines in order to analyze demographic and workforce trends

Education

The Nebraska Center will be the main site for training future providers in public-sector behavioral health and will provide training programs in all disciplines with a training site for public-sector behavioral health. This will include the following special features:

- Specialized advanced training tracks for public-sector behavioral health specialists with training appropriate for the needs of that population
- Provide training opportunities in all areas and regions throughout the state
- Interdisciplinary training with a focus on teamwork, including shared clinical, educational, and research opportunities for all trainees
- Opportunities for high school and university students to be exposed to behavioral health recruitment through programs similar to the Rural Health Opportunities Program (RHOP)
- Tele-health educational services that enhance supervision for trainees in sites across the state
- A Continuing Education Program, which would be produced and broadcast throughout the state

Service

The Nebraska Center will require a facility to integrate the varied clinical service, education, research, and outreach functions. It also will be a national model for academic, government and private partnerships in mental health and substance abuse services.

- The Nebraska Center will serve as a resource to Nebraska's mental health regions by helping them meet their identified needs.
- The Nebraska Center will be a core facility for tele-health and services that enhance Tertiary Care Services throughout the statewide Center of Excellence via consultation for treatment-resistant or complicated cases.
- Recruitment of mental health providers to Nebraska will be aided by tracking and retaining professionals trained in the Nebraska Center and through enhanced opportunities to participate in education and research.

- The Nebraska Center will provide local access to critical services for the large metropolitan area population across a continuum of care. This will include services currently unavailable locally, such as inpatient services, and services which are underutilized, such as mid-intensity levels of care.
- The Nebraska Center will include a much needed Single-Point Public Sector Crisis and Triage Center, which will reduce the burden on strained hospital emergency departments and law enforcement, while also providing patients with more timely access to needed services.

Research

The Nebraska Center will develop a research program in behavioral health to provide the infrastructure for recruiting researchers and inducements to funding agencies. Investment in infrastructure will ultimately establish a 'core facility' supported through extramural contracts and grants that augment, not detract from, clinical and educational excellence. The research program will include the following features:

- Establish a clinical trials network across Nebraska that will include clinician co-investigators throughout the state. The Lymphoma Study Group, which has made Nebraska a national leader for improved quality of care via such partnerships between academia and clinical practitioners, can serve as a model for behavioral healthcare.
- Invite civic-minded benefactors to endow professorships and lines of research in psychiatry, mental health and neuroscience to assure more rapid progress in developing treatments and programs promoting recovery from mental illness.
- Partner with corporate leaders in Nebraska to study workplace behavioral health issues such as depression and substance abuse for improved employee health and productivity.
- Evaluate outcomes of interventions conducted under the auspices of the Nebraska Center, as well as service research of interest to Nebraska state government.

V. CLOSING

Creighton University Medical Center and the University of Nebraska Medical Center are willing to assist in the development of an improved model for delivering community-based behavioral health services in Nebraska. As partners, the state's only two academic health centers can commit considerable resources to developing a behavioral health program that will reach out to serve the entire state.

If new and adequate resources (financial, infrastructure and facilities) are provided to the new Nebraska Center, the staff of the two academic health centers will deliver state-of-the-art education, research, outreach and select patient services to all Nebraskans. The Nebraska Center will become a national model for the innovative delivery of these needed programs at the community level across the state. The academic medical centers also will provide staffing and expertise through the Nebraska Center to offer appropriate inpatient, crisis care and community-based services to patients in the greater Omaha metropolitan area.

The two academic health centers fully realize that they can only be part of the solution to improved behavioral health services in Nebraska. They are eager to join with local, regional and state partners to help advance access and quality of care to this special population of patients.

The goal of all Nebraskans is to improve our behavioral health system for delivery of services and to maximize the impact of limited resources available to advance this cause. The creation of the Nebraska Center for Excellence in Behavioral Health will permit the educators, researchers and care givers at Nebraska's academic medical centers to more closely team with providers, patients, patients' families, mental health advocates, employers and local and state leaders from across Nebraska to achieve this goal.

Nebraska stands at an historical crossroads in deciding the future of how behavioral health care services will be delivered to its citizens. Creighton University Medical Center and the University of Nebraska Medical Center are ready to assist the state in traveling down this new road to better access, quality and financial viability.

VI. APPENDIX

A. Behavioral Health Center Team

Academic Health Science Centers

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B. Regional Center Statistics

Regional Center admission -- The following table describes the number of admissions to acute and secure levels of care at the three regional centers:

	FY 00	FY 01	FY 02	FY 03
Adult Admissions	1096	1086	1097	1115
<u>Child/Adolescent. Admissions</u>	<u>84</u>	<u>134</u>	<u>110</u>	<u>130</u>
TOTAL ADMISSIONS	1180	1220	1207	1245
Adult Discharges	1178	1094	1087	1165
<u>Child/Adolescent Discharges</u>	<u>65</u>	<u>110</u>	<u>113</u>	<u>115</u>
TOTAL DISCHARGES	1243	1204	1200	1280
Adults in Residence on Last Day	468	478	469	432
<u>Child/Adol. In Res. On Last Day</u>	<u>19</u>	<u>31</u>	<u>17</u>	<u>19</u>
TOTAL IN RESIDENCE	487	509	486	451

Admissions by region -- The majority of regional center admissions are persons committed by Mental Health Boards to inpatient (acute or secure) care. The following table lists the number of consumers who were committed to and admitted to inpatient care at Regional Centers by Region:

REGION	# OF COMMITMENTS TO RC's	% of TOTAL	% of Population
Region 1*	18	2.1%*	5.3%*
Region 2	46	5.3%	6.0%
Region 3	225	20.5%	13.0%
Region 4	69	7.9%	12.6%
Region 5	216	24.7%	24.2%
Region 6	274	31.3%	38.9%
Out of State	72	8.2%	NA
TOTAL	874		

* Does not include commitments to Regional West Hospital in Scottsbluff. Thirty-four (34) individuals were committed to Regional West in FY 2003 bringing the total commitments to 52.

Lengths of stay snapshot -- In August 2003 both Norfolk Regional Center and Hastings Regional Center records were reviewed to collect a snapshot of the lengths of stay for patients being served at Regional Centers on June 30, 2003. The following tables show the results by Regional Center:

LOS	HRC	%	NRC	%	Total	%
1 to 30 Days	25	41%	23	14%	48	21%
31 to 89 Days	16	26%	20	12%	36	16%
90 to 180 Days	7	12%	47	28%	54	23%
181 to 365 Days	7	12%	24	14%	31	13%
366 to 730 Days	3	5%	23	14%	26	11%
731 to 1460 Days	3	5%	21	12%	24	10%
2 to 13 Years	0	0%	12	7%	12	5%
Total	61		170		231	

Regional Center Lengths of Stay for patients discharged during FY 2003 are shown in the following table:

	Hastings Regional Center	Lincoln Regional Center	Norfolk Regional Center	TOTAL
Discharges	542	326	297	1165
Average Length of Stay	95.5	264.7	210.2	172.1
Median Length of Stay	40	72	121	54

On Nov. 4, 2003, the three Regional Centers listed 32 individuals as being discharge ready and waiting for a placement in community services. Thirteen individuals were listed as ready for discharge at the Norfolk Regional Center and 16 were listed as discharge ready at Hastings Regional Center. Of the 32 individuals, 12 had waited for placement in the community more than 60 days since becoming discharge ready.

C. Expenditures

Expenditures for FY 03 for adults in the behavioral health systems funded by HHSS.

SERVICE	Regional Centers	NBHS*	Medicaid	TOTAL
Adult Emergency Services	\$0	\$9,687,434	\$123,110	\$9,810,544
Adult Inpatient Services	\$30,445,156	\$783,428	\$5,410,027	\$36,638,611
Adult Residential Services	\$9,530,346	\$14,637,706	\$80,511	\$24,248,563
Adult Non-residential Services	\$2,713,609	\$18,787,162	\$10,307,125	\$31,807,896
Psychotropic Drugs	**	\$1,169,831	\$53,902,721	\$55,072,552
TOTAL	\$42,689,411	\$45,065,561	\$69,823,494	\$157,578,466

* Includes Medicaid Rehabilitation Option totals as part of NBHS. Does not include contracts with Native American tribes.

** The cost of Regional Center drugs is included in the cost of delivering services.

Appendix B: The RHEN Model for Behavioral Health

The Rural Health Education Network (RHEN) began in the 1980s to develop a pipeline of health professionals to serve rural Nebraska. As a “Grow Our Own Program” the University of Nebraska Medical Center (UNMC) partnered with communities across the state to provide UNMC students opportunities to receive part of their clinical training under the supervision of volunteer health profession faculty remote from the main medical campuses.

In the early 1990s the RHEN model began to link UNMC resources with junior and senior high students to expose them to health careers and provide them with role models and resources to encourage their entrance into health professions and return to rural areas upon completion of their degrees. At the same time a program called the Rural Health Opportunities Program (RHOP) began as a partnership with Wayne State College and Chadron State College to pre-admit students to health profession training upon acceptance into their undergraduate pre-health profession areas of study. RHOP now accepts students in nine different pre-professional programs and has more than a 70% success rate of students entering health professions in rural communities upon completion of their health profession education.

In 2001, UNMC received federal support through the Health Resource Services Administration (HRSA) to develop local Area Health Education Centers (AHECs) across the State to complement the activities of RHEN. The AHECs have expanded the reach of RHEN to meet the regional needs of each Center’s communities and began educating students in grades as early as K-8 about health careers and healthy lifestyles. The AHEC Centers, which are independent 501-C-3 organizations, would work with local resources to assure students and communities would mutually benefit from student training opportunities in behavioral health being made available across the state through the Behavioral Health Education System and Sites. Because AHEC Centers are governed by community boards, a goal may be to include and support consumers of behavioral health services on these boards.

In the fields of behavioral health, RHEN will collaborate with local AHEC programs and work with academic institutions that provide behavioral health tracks to design early exposure and familiarization to behavioral health careers in the K-12. RHEN will also provide education to dispel the myths and misinformation surrounding mental health and behavioral health, work with academic units to develop off campus clinical training opportunities under the direction of qualified preceptors, and work with communities to provide support resources such as housing and subsistence to accommodate students at remote clinical training sites.

